

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Koch (rural)
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Robert Koch Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 207 days
(Specify whether years, months or days)

In this community 30 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 5256 Bonita Avenue
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME SCHIMMER, NICHOLAS

3. (b) If veteran, name war _____

3. (c) Social Security No. 492-24-2757

4. Sex Male 5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Katherine Schimmer

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased May 20 1888
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>	<u>1</u>	<u>2</u>	hr. min.

9. Birthplace Hungary
(City, town, or county) (State or foreign country)

10. Usual occupation Barber

11. Industry or business _____

MOTHER, FATHER {

12. Name John Schimmer 4

13. Birthplace Hungary
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Schwertler 4

15. Birthplace Hungary
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Records

(b) Address Robert Koch Hospital

17. (a) Burial (b) Date thereof 6/24/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation S. S. Peter & Paul

18. (a) Signature of funeral director J. L. Ziegenhein & Sons

(b) Address 7027 ravois

19. (a) 6-23-48 (b) Robert Koch Hospital
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22
year 1948 hour 12 minute 50 A. M.

21. I hereby certify that I attended the deceased from 11-28-47, 19____, to 6-22-48, 19____;
that I last saw h im alive on 6-22-48, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis

Due to _____

Due to 13h

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature John T. ... (M.D. or other)

Address Robert Koch Hospital Date signed 6-22-48

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address. 7027 Grand

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.